LETTERS *to the Editor*

Position on Early and Periodic Screening

TO THE EDITOR: Recently, the federal government has mandated a health screening program for the Medicaid-eligible population under age 21. In California, the Brown Bill AB-2068, now Chapter 1069 of the Health and Safety Code, is the new State financed program for child health and disability prevention. It is to provide for early and periodic assessment of child health. Physicians who care for children have the obligation to evaluate possible benefits and perils that may develop through implementation of this legislation.

It is unfair to develop schemes that may be for publicity value or serve to justify programs of questionable validity. Prevention of disease by screening is so appealing a concept that wishful assumptions have been made that the methodology is available to assure success. Legislators and the public seem to accept anything that promises to achieve this goal. The value and limitations of mass screening techniques are little understood, yet mass screening has become the modern mystique—the answer to health problems. Can mass techniques be successful in early detection and prevention of physical and mental disability in children? Some think so. These opinions were never proven before legislation was enacted to start mass screening. Health officials must beware of the dangers of implementing screening programs that may be medically and philosophically unsound.

We recognize that the needs of all children are not being met. Mass screening has been assumed to be better than nothing, or a place to start. Until adequate data are available to confirm or deny that massive unproven screening is of value, it would be prudent to conduct pilot studies on a cross-section of children in this state. Specific innovative programs need to be developed for those without care that are comparable to the best. Where medical care is not available because of maldistribution of physicians, isolation, or with migrant children, incentive programs must be created.

An article about early and periodic screening in THE WESTERN JOURNAL OF MEDICINE, March 1974 [McNamara JJ: Early and Periodic Screening—Medi-Screen Program Structure and Standard Setting. West J Med, 120:263-266, Mar 1974] stated:

> "This one-to-one interaction is not the model envisioned in Medi-Screen. . . . Determining health status and detecting abnormalities may lead to diagnosis and treatment and may prevent the progression of illness. However, direct responsibility for the health care of populations, except in limited contexts, does not exist. The problem of evaluation and follow-up after the health data are collected is the major challenge facing a program such as Medi-Screen."

Good communication is essential to getting a proper history. A program planned without interaction or responsibility toward the child can become a dehumanizing experience that will never foster communication. It will encourage the authoritarian approach that says, "I know what you need—don't communicate your feelings—my values must be your values." Communication permits one to pick up the mixed message where the tone and content do not agree. The establishment of rapport in a one-to-one relationship, plus the skill and ability to clarify of the interviewer will determine the quality of the history obtained. In turn, this will best direct the child's care.

A good medical system provides trust, communication and mutual respect. It must be planned so that receivers and providers want to give their cooperation. Screening programs run the great risk that those who do not have a primary source of medical care, such as a hospital plan, a clinic or a personal physician, will be processed in a style that will leave them in the same position—no place for treatment, no funds, no follow-up, and no one person responsible.

Health is based on physical, intellectual, emotional and social factors interlocked in a complex manner. It is a continuum that begins at birth and extends throughout life. Can we assume that if we stop and screen a child at one point on

this continuum, we can prevent and detect disease? Can we expect screening of individual organ systems or the measurement of certain biological parameters to accomplish this? There is no definite knowledge that proposed procedures will be of value to children and there is potential for harm.

Health officials must beware that activism without rationality, even for the noblest ideals, may exploit those with the greatest problems. Funds to meet the needs of children must not be dissipated by the commercial motivation to capitalize on a screening process. On the other hand, funding must be adequate to purchase the required services or a hoax will be perpetrated on these children. Many who are getting inadequate diagnosis and treatment are those who are poor, uneducated, uncared for, unneeded, unwanted and unloved. They have experienced second rate medical evaluation, prevention, and therapy in the past—let us not offer them more of the same.

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Tricuspid Valve Replacement

TO THE EDITOR: I recently read the article entitled "Tricuspid Valve Replacement in Carcinoid Heart Disease," by Dr. Harold G. Lund, Dr. Richard J. Cleveland, Dr. Lowell H. Greenberg, Dr. Maurice Lippmann and Dr. Malin R. Dollinger. This was published in the May, 1974 edition of THE WESTERN JOURNAL OF MEDICINE, Volume 120, Number 5 and appeared on Pages 412-415.

The authors' concluding statement reads: "This appears to be the first reported patient with carcinoid heart disease to have successfully undergone tricuspid valve replacement." An article (of which I was one of the authors) entitled "Carcinoid Heart Disease: Surgery for Tricuspid and Pulmonary Valve Lesions," was published in the August, 1973 edition of *The American Journal of Cardiology,* Volume 32 on Pages 229-233.

Doctor Lund's article stated that their patient was operated upon in June, 1972. Our patient was operated upon on January 28, 1972—four or five months before Doctor Lund's patient was operated upon. Although Doctor Lund's patient died four months following surgery, our patient is living and well as of this date, having just graduated from the University of Nevada at Las Vegas. Since the dates of our operations were fairly close (being only four months apart), I can see how our article may have been missed.

We do not claim being the first to replace the tricuspid valve. In our article we made note of the fact that in 1966 Dr. J. M. Aroesty had described a patient's having been successfully operated upon for carcinoid heart disease. We corresponded with Doctor Aroesty, and he stated his patient did well until October, 1971, when he died of increasing hepatic failure.

Doctor Lund et al obviously had not reviewed the literature sufficiently to determine the fact that Doctor Aroesty was the first to successfully replace the tricuspid valve for carcinoid disease. I believe we were second, and Doctor Lund et al were third.

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EDITOR'S NOTE: For this journal's part in the record, let it be noted that the article by Lund and coworkers was first submitted for publication in May, 1973, and was returned to him with suggestions for revision. Hence, as Dr. Kay correctly surmised, they had no way of knowing, from a survey of the literature and then current indexes, of the paper by Kay and coworkers which appeared in August, 1973.